Medicare Program Integrity Manual

Chapter 7 - MR and BI Reports

Table of Contents
(Rev. 52, 10-10-03)

1 - Medicare Focused Medical Review Status Report (MFSR) - (Rev. 3, 11-22-00)

MFSR is a management report that allows HCFA to monitor the services being targeted for investigation and correction by carriers and the success of corrective actions being employed to address those areas. Carriers can determine to focus efforts on specific services for a number of reasons as explained in the PIM Chapter 2, Section 2. The MFSR collects the following kinds of information:

- Identification of aberrant providers selected to target for corrective action in a given fiscal year (FY);
- Sources of data which contributed to identification and selection;
- Cause of problem;

- Corrective action; and

- Outcomes of corrective action.

For a given FY, carriers report on the identified areas of abuse 3 times (i.e., the initial submission, the follow-up submission, and the final submission). Follow-up information indicates whether corrective actions taken were effective in resolving the areas of abuse.

Carriers are required to submit the initial FY MFSR 1 month following the end of the FY. They update the MFSR at 12 months following the FY. A final MFSR update must be submitted 24 months following the end of the FY.

2 - Program Integrity Management Reports (PIMR) - (Rev.)

Reserved for future use.

3 - Medicare Fraud Unit Quarterly Status Report - (Rev. 3, 11-22-00)

The fraud unit documents the activities it performs and reports them to HCFA using the CROWD system detailed in Part 3 §3898.5 of the Medicare Intermediary Manual. The fraud unit must maintain data on the following topics:

- Complaints (volume, source, processing times, dispositions);

- Volume and kinds of referrals to OI;

- Networking activities; and

- Types of fraud or abuse identified and corrective actions taken, including administrative actions.

4 - FID - (Rev. 3, 11-22-00)

The FID will capture information on current cases that have been referred to the OIG. The FID will also report other pertinent information. Some examples of the types of data included in the FID are:

- Subject of an investigation (i.e., hospital, SNF, HHA, CORF, etc.);

- Allegation information/nature of the scheme;

- Status of the case;

- Disposition of a case (i.e., administrative action, prosecution, exclusion, settlement, etc.); and

- Contact person.

The FID will also have monitoring/reporting capabilities such as:

- The number of cases by subject, sub-subject, region, contractor, HCPCS code, etc.;
- Timely suspensions;
- Length of time to close out a case;
- Number of cases referred to OIG/FBI;
- Number of cases accepted by OIG/FBI;
- Number of cases sent back for additional development; and
- Dollar amount recovered through settlement,suspensions, recoveries other than case settlements.

5 - Quarterly Carrier MR Savings Report - (Rev. 3, 11-22-00)

Carriers must at the end of each quarter, prepare, and submit the carrier MR savings report to HCFA. A separate report is prepared for each carrier office that receives a separate budget allocation from HCFA (does not apply to home offices).

5.1 - Purpose and Scope - (Rev. 3, 11-22-00)

The quarterly carrier MR savings report is the primary source of current information about the carrier's program savings from MR activities and the cost benefit ratios resulting from review activities.

The data are used by HCFA for:

- Preparing reports about the costs and savings for Part B MR;
- Serving as a source for contractor evaluations;
- Identifying effective prepayment screens;
- Comparing the performance of individual carriers;
- Identifying problem areas for resolution; and
- Measuring trends in pre-payment and post-payment activities.

5.2 - Submission to HCFA - (Rev. 3, 11-22-00)

The "Carrier MR Savings Report" is completed quarterly. The report must be entered into the HCFA database within 45 days of the end of the fiscal year quarter. In addition, carriers send a copy directly to the RO and send the hard-copy original and any attachments to:

Health Care Financing Administration
Program Integrity Group
Mail Stop: C3-02-16
7500 Security Blvd.
Baltimore, MD 21244-1850

5.3 - Completing the Carrier MR Savings Report - (Rev. 3, 11-22-00)

A - Page One - Quarterly MR Savings Data

- Contractor Number - The carrier identification number HCFA has assigned to the locality.
- Contractor Name - Carrier corporate name.
- Fiscal Quarter and Year - Quarter 01, 02, 03, or 04 and the FY.
- Contact Name - The name of an individual who can answer questions concerning the information on the report.
- Contact Phone - The contact's phone number.
- Extension - Contact's phone extension number.
- Prepayment Cost - Total administrative cost of the carrier's prepayment activities funded by line 5 of the budget this quarter.
- Postpayment Cost - Total administrative cost of the carrier's postpayment activities funded by line 5 of the budget this quarter.
- HCFA 1565A, line A1 - The total of line A1 entries for this quarter.
- HCFA 1565, line 11 - The total of line 11 entries for this quarter.
- HCFA 1565A, line A3 - The total of line A3 entries for this quarter.
- I Dollars Den/Red - Net category I savings.
- I Claims Den/Red - The number of claims denied or reduced through category I screens.

- I Services Den/Red - The number of services denied or reduced through category I screens.

- Hardcopy Sent - Whether a copy of the report or supplemental report information have been sent to HCFA. Enter Y (yes) or N (no).

- Category II Screens - The number of local category II screens in operation.

- Physicians/Suppliers - The number of physicians/suppliers who generated one or more assigned or unassigned claims during the prior year.

- Remarks - Carriers enter any offset claimed. They indicate the reason and explain any abnormalities in the report.

B - Pages Two and Three: Category II Mandated Screen

- SCRN - The identification number of the mandated screen being reported. Ten screens may be entered on each page. (See MCM §7529.1-.20.)

- SUSPENSIONS # Claims - The number of claims edited for review by this screen during the quarter.

- SUSPENSIONS # Services - The number of services medically reviewed on the edited claims.

- SUSPENSIONS Gross $ - The monetary value of the services reviewed. Show whole dollar amounts; round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.

- DENIED/REDUCED # Services - The number of suspended services that were denied or reduced when reviewed.

- DENIED/REDUCED Gross $ - The monetary value of the services denied and the gross value of the reductions. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.

- REVERSALS # Services - The number of services denied or reduced under this screen that were reversed on appeal during the quarter being reported.

- REVERSALS Gross $ - The monetary value of the reversals. Round cents to the nearest dollar. Do not make reasonable charge or coinsurance reductions.

- TOTS - The totals will be calculated by the automated system. Carriers do not enter data on this line.

C - Pages Four and Five - Category II Local Screen

Column headings and definitions correspond to those in PIM Chapter 7 §5.3 subsection B. Carriers must show the top 20 local screen identification numbers in the "SCRN" column (10 screens on each page). The "top 20" will generally fluctuate between quarters. They round all cents to the nearest dollar for entry and use gross values that have not been adjusted for reasonable charge or coinsurance. The system will calculate those reductions. They enter these screens in descending order with the screen with the highest "Denied/Reduced Gross $" listed first.

AOLS - Carriers enter the column totals of those local screens not included in the top 20.

D - Page Six: Category III and Postpayment

- Overpayments Est in Qtr - The total value of all overpayments identified as a result of activities funded through line 5 of the budget.

- Claims Suspended - Number of claims edited due to category III screens.

- Services Suspended - Number of services suspended as a result of Category III screens.

- Value of Service Sus - The dollar value of all services edited from routine processing for Category III review. Carriers round cents to nearest dollar. They do not adjust for reasonable charge or coinsurance reductions.

- Services Denied/Reduced - Number of services denied or reduced as a result of Category III screens.

- Denied/Reduced Dollars - Gross dollar amount of the Category III services denied or the amount of the reduction. Carriers round cents to nearest dollar. They do not make reasonable charge or coinsurance adjustments.

- # Flagged Phys/Suppliers - The number of physicians and suppliers flagged for Category III review.

- Overpayments Recovered - Overpayments recovered as a result of activities funded through line 5 of the carrier budget.

- Closed Cases - The number of comprehensive reviews completed during the quarter (do not include program integrity reviews).

- Pending Cases - The number of comprehensive reviews pending at the end of the quarter (do not include program integrity reviews).

- Manually Reviewed Claims - The number of claims manually reviewed during comprehensive reviews this quarter.

- Cases Referred to OIG - The number of cases referred to OIG.

- Cases Returned by OIG - The number of cases returned by OIG for final administrative action.

- Sanctions Effectuated - The number of physicians/suppliers sanctioned upon receipt of an OIG sanction notice during the quarter as a result of activities funded through line 5 of the budget.

- CMP Cases Effectuated - The number of CMPs levied upon receipt of an OIG CMP notice during the quarter.

- Sav Cred MR Sanctions - The savings attributed to sanctions during the quarter. Carriers send documentation to HCFA substantiating the credit claimed.

- Sav Cred CMP Cases - The savings attributed to CMP cases during the quarter. Carriers send documentation to HCFA substantiating the credit claimed.

6 - Quarterly Intermediary MR Savings Report - (Rev. 3, 11-22-00)

These revised reports replace all prior quarterly MR savings reports for hospice, SNF, HHA, OPT/CORF and ESRD facilities

6.1 - Submission - (Rev. 3, 11-22-00)

The intermediary completes the savings report for each calendar quarter and submits electronically through the Part A Medical Review System within 30 days of the end of the reporting quarter along with the RBS to the HCFA data center. (See Screens 6 and 7.) It does not submit the reports by hard copy. (See §2301.3 of Intermediary Manual, Part 2.) It also submits a copy to the RO.

6.2 - Completing the Quarterly Intermediary MR Activity Report - (Rev. 3, 11-22-00)

The intermediary enters data in columns provided for each category of provider claims. (See Screens 6 and 7.)

6.2.1 - Screen 6

A - Hospice Claims

- Number of hospice bills denied; and

- Number of hospice bills charged to lesser level (e.g., inpatient respite care changed to routine home care rate).

B - ESRD Claims

- Number of ESRD bills denied for medical necessity; and
- Number of ESRD claims denied because the services should have been included in composite rate.

C - SNF Continued Stay Denials

- Number of SNF bills reviewed; and
- Number of SNF bills fully/partially reversed.

D - CORF

- Number of CORF bills denied.

E - Audits Days Visits/Charges

- Number of HHA visits reviewed on MR audit;
- Outpatient hospital charges reviewed on MR audit; and
- Other provider charges reviewed on MR audit.

F - SNF Audits

- Number of SNF days reviewed on MR audit; and
- Number of SNF days denied on MR audit.

G - Demand Bills Reviewed

- Number of demand bills reviewed for SNFs, HHAs, and other; and
- Amount of savings claimed for HHA and other demand bills that the intermediary affirms.

6.2.2 - Screen 7 - (Rev. 3, 11-22-00)

A - PT

- Number of PT bills reviewed;

- Amount of charges for PT bills reviewed;
- Number of PT bills denied; and
- Amount of charges denied for PT bills reviewed.

B - OT

- Number of OT bills reviewed;
- Amount of charges for OT bills reviewed;
- Number of OT bills denied; and
- Amount of charges denied for OT bills reviewed.

C - Speech Therapy (ST)

- Number of ST bills reviewed;
- Amount of charges for ST bills reviewed;
- Number of ST bills denied; and
- Amount of charges denied for ST bills reviewed denied.

6.2.3 - Other Review Data - (Rev. 3, 11-22-00)

A - MR of SNF Bills

- Number of payment claims reviewed
- Number of payment claims denied
- URC/SNF continued stay denials reviewed
- URC/SNF continued stay partially/fully reversed
- Demand bills reviewed

B – MR With Use of Therapy Screens

	PT	OT	ST
Number of Bills Passing Screens			

Number of Bills Suspending Screens

Charges on Bills Passing Screens

Charges on Bills Suspended Screens

Number of Bills Reviewed

Number of Bills Denied

Charges Denied

C - Other Therapy MR

	PT		OT		ST	
	P/P Sample	Other	P/P Sample	Other	P/P Sample	Other
Number of claims reviewed						
Number of claims denied						
Charges reviewed						
Charges denied						

7 - FMR Activity Report - (Rev.45, 07-25-03)

Intermediaries must complete the report semi-annually. (See Exhibit 2.) The reporting periods must cover the first two quarters of the FY (i.e., November thru April) and the last two quarters (i.e., May thru October) of the FY. Within 45 days of the end of the reporting periods, i.e., by May 15 for the first reporting period and by November 14 for the second reporting period, *they submit the report to the RO.*

Report the following elements:

- Date report was prepared;
- Contact name and telephone number;
- Period covered by the report;
- FMR criteria (specific revenue code, HCPCS code, provider, etc.) being reviewed;
- Reason for selection. Show the specific reason the FMR edit was selected (e.g., the providers rank in the top 5 percent in utilization of MRIs, referral from fraud unit, utilization aberrancy, or new technology);

- Date established (the date the edit was initially established);

- Actions taken. Intermediaries show the actions taken to resolve problems, e.g., educational efforts, fraud referrals, development of LMRP (attach copy); and

- Effectiveness. Intermediaries show the following:

    - Number of bills medically reviewed;

    - Percent of bills partially or fully denied;

    - Average or actual charges, days, or visits reviewed under criteria;

    - Average or actual charges, days, or visits denied;

    - Percent of increase or decrease of days/visits/charges denied from previous period if edit has been in place during a prior period;

    - Approximate charges billed in prior period versus current period to show cost avoided as a result of provider practice change;

    - The cost benefit ratio (CBR) which is based on the average unit cost for review per bill type and savings as computed on the RBS. The CBR is required if you are using denials as the reason for continuing the edit;

    - Other measurable result or reason the edit is being continued. If an edit is discontinued or modified and one of the above results are not applicable, give the reason for discontinuation or modification; or

    - Estimated or potential overpayment for referrals to fraud.

- Reasons for denials. Intermediaries list reasons claims are denied under this edit; and

- Status. Intermediaries show continued, discontinued, or modified status, as applicable. If the edit was modified prior to the reporting period, the FMR criteria described must reflect the modified edit. If the modification occurs during the reporting period, they identify the changes.

A - Summary Sheet

Intermediaries must provide the following information on a cover sheet to the report:

- Number of edits reviewed this period;

- Number of edits modified or discontinued this period; and

- Number of edits reviewed in effect for 12 months or more.

They show the edit number on the report and indicate any actions taken by the intermediary or the providers as a result of the problem being identified.

EXAMPLES: Edits 1, 5, and 6 - conducted provider education meetings.

Edit 6 - provider changed billing practice.

Edit SNF 2 - generated provider bulletin, no change in billing practices to date.

When applicable, intermediaries include on the cover sheet any of the following information:

- New hardware or software development that the intermediary found particularly effective in conducting data analysis. Include any commercial products reviewed and believe would be of benefit;
- Any new patterns, trends, or problem identifications found to be significant. This includes any referrals to the fraud unit;
- Any new coverage issues that require clarification or development of national policy; and
- Any new FMR issues that need to be brought to the attention of other intermediaries, carriers, the QIOs, ROs, and/or CO.

8 - Report of Benefit Savings (RBS) - (Rev.) - (Rev. 3, 11-22-00)

Contractors transmit the RBS for each calendar quarter within 30 calendar days after the end of the reporting quarter. They may add, browse, update, or delete records at any time, and as many times as needed, until CO invokes the close out function at the end of each quarter. They will be notified by CO in the HCFA newsletter when this is to take place. Once the record has been closed they may only browse it. If for any reason a modification is needed to a closed record, they submit a facsimile of the transmitted report with the changes highlighted to:

Health Care Financing Administration
Program Integrity Group
Mail Stop: C3-02-16
7500 Security Boulevard
Baltimore, MD 21244

8.1 - Types of Savings to Report- Denials - (Rev. 3, 11-22-00)

Intermediaries report all savings attributable to denials if the services were non-covered under §§1862(a)(1), (7), (8), (9), (10), (12) and (13) of the Act, or because they were not documented on the record as:

- Having been ordered by the physician or provided to the patient; or

- Were determined through MR not to meet other documentation or coverage requirements of the law, regulations or coverage policy issuances.

Intermediaries report savings resulting from MR in the following areas:

- Home health visits;
- Inpatient hospital and SNF ancillaries billed to Part B;
- Non-covered services furnished by a RHC, rehabilitation facility and/or CORF;
- Program integrity reviews performed and overpayments recovered;
- HHA compliance and post-payment reviews;
- Hospice services, i.e., charges for denied days/services and/or difference between charges for level of care billed and level of care determined to be reasonable and necessary;
- Inpatient SNF;
- Overpayments and savings from post-payment MR. The amount reported must be the direct result of MR and determined to be an overpayment;
- Outpatient hospital, HHA and SNF services;
- Laboratory, supplies, or drugs which exceed frequencies outside of the ESRD composite rate and are not medically necessary;
- Claims denied because a provider failed to comply with contractor request for documentation within prescribed time frames;
- Charges denied or deleted from the claim as a result of contractor identification of billing errors during the course of MR. For example, the contractor questions the medical necessity of a service and finds the service was billed in error; and
- Difference between charges for services billed and charges for services determined to be medically necessary e.g., reduction of air ambulance service charges to charges for land ambulance.

The services non-covered under §§1862(a)(1), and (7),(8),(9),(l0),(l2) and (l3) of the Act are items and services that are not reasonable and medically necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

When reporting savings, intermediaries apply the following rules:

- Report savings resulting from medical review by:
    - Health professionals;
    - Clerical staff trained in medical and utilization review and using guidelines developed by health professionals; and
    - Electronic edits developed by health professionals and approved by the RO;
- Take credit for denials paid under waiver;
- Breakdown HHA savings by type of visit;
- Do not include savings resulting from bilateral joint reviews. It is a claims processing function to assure that bilateral joints are inserted during the stay;
- Do not report as savings electronic or automatic manual denials of excluded or non-covered services which do not require exercise of medical judgment (e.g., excluded ICD-9 codes; V70.0 routine general medical examination);
- Take credit for the actual number of days on a SNF demand bill if the reviewer concurs with a provider's non-covered determination based on review of the bill and medical information. For services prior to 1/1/89 and on and after 1/1/90, report the coinsurance amount beginning with the 21st day of each benefit period. For services 1/1/89-12/31/89 report coinsurance amount for the first 8 days; and
- For all other SNF bills, take credit for the number of days the reviewer determines to be non-covered. Report the actual coinsurance amount.

8.2 - Completion of the RBS - (Rev. 3, 11-22-00)

Intermediaries input data for the RBS through the personal computer or terminal via the HCFA data center. They input only the bold data elements. Computations are performed by the system. Five screens are provided to capture all data from the RBS.

Intermediaries enter the following information at the beginning of screen number 1.

Contact Name Enter the name of the individual responsible for completing the report.

Contact Phone Enter the area code and phone number of the individual responsible for the report.

The savings categories are on the screens in codes numbered 1 thru 32.

CODE	CATEGORY	SAVINGS
1	Hospital PPS	Charges for excluded or noncovered services billed by hospitals detected by PRO; services for hospice patients related to terminal

		illness.
2	Hospital Non-PPS	Same as PPS; Noncovered services in foreign hospitals.
3	Hospital Outpatient (OP)	Non-covered OP services billed by a hospital.
4	Hospital Ancillary-IP	Non-covered ancillary services billed by a hospital; includes Part B billing for an inpatient and ancillary review when a PRO denies a stay.
5	SNF Days	Inpatient SNF days determined to be non-covered.
6	SNF OP Charges	Non-covered OP services billed by a SNF.
7	SNF Ancillary Charges	Non-covered ancillary services billed under Part B for a SNF inpatient; Ancillary services denied on a Part A bill for SNF inpatient.
8	ESRD	Non-covered charges; Charges outside of composite rate which are medically unnecessary for hospital based and free standing facilities.
9	OP PT/Rehab	Non-covered services billed by rehab facilities (bill type 74) other than CORFs.
10	CORF	Self explanatory.
11	RHC	Self explanatory.
12	Other Part B	All Part B non-covered services not covered by an existing category.
13	Program Integrity Savings	Recoveries from PI and other audits conducted.
14	Open Biopsy	Number of reviews resulting in both a DRG assignment to closed biopsy and lower weighted DRG.
15	OP Hospital Audits	Recoveries from non-covered services identified on OP hospital audits.
16	Other Audits	Recoveries from non-covered services identified on all other audits.
17	SNF Demand Days	SNF days determined to be non-covered by provider, and the contractor concurs.
18-23	HHA Visits	Visits provided under a home health plan of care (HCFA-485) determined to be non-covered on prepayment review.
24	HHA DME/Supplies	Non-covered charges for DME/supplies under a home health plan of treatment detected on pre or post-payment review.
25	OP Home Health	Non-covered charges billed by HHAs under Part B, not under HCFA-485 plan of care.
26	Hospice	Difference in charges when inappropriate hospice level is billed and non-covered services.
27-32	CCR/HHA visits	HHA visits determined to be non-covered under post-payment review (i.e., coverage compliance or audit).

Intermediaries enter data in the four columns provided for each category on Screens 1-3. They round all charges to the nearest whole dollar. The four columns are:

- TOT DEN SER CHG FOR QTR;

- DEN PD UND WAV OF LIAB;
- DEN REP ON RECON H&A; and
- APP-DED CO INSUR AMTS

A	Total Denied Services/Charges for Quarter	Enter the total charges, visits, or days denied under MR in the reporting quarter.
B	Denials Paid Under Waiver of Liability	Enter the charges/days/visits paid under waiver of liability. If you previously reported a claim as denied not paid under waiver, and it is subsequently paid under waiver, report the information in this column only. Exclude denials paid under waiver which were overturned in the current quarter (i.e., included in Item D).
C	Charges Net of Waiver	The difference between Items A and B. Computations are performed by the system.
D	Denied and Reported Charges, Days, or Visits Overturned on Informal Re-Review, Reconsideration, Hearing or Appeal	Enter previously denied charges, days or visits for denials which were overturned (i.e., paid as covered services) upon appeals. Enter these charges, days or visits **only** if they: • Were denied (including denied charges, days, visits paid under waiver); • Were reported as savings in a previous report; or • Are reported as savings for the current quarter in Item A
E	Net Denied Charges, Days, or Visits	The ifference between Items C and D. Computations are performed by the system.
F	Conversion Factors	HCFA converts days, charges, and visits to costs on the RBS. The updated factors apply to the reported savings shown on the RBS effective for the quarter beginning 10/95. The factors are entered by the system.
G	Factored Amount	The product of net denied charges, days or visits times the conversion factor. This is the factored amount from which Item H (the applicable deductible and coinsurance amounts) are deducted. Computations are performed by the system.

H	Applicable Deductible and Coinsurance Amount	Enter the applicable deductible and coinsurance amounts for Part A and Part B. If the contractor adjusts the deductible amounts later (e.g., as a result of an adjustment), do not adjust the previously reported savings. Show an amount in this field for all Part B services that are subject to the 20% coinsurance (i.e., categories 3,4,6,7-12, and 25). Show the sum of applicable deductibles and the 20% coinsurance amounts. The deductible and coinsurance amounts are the amounts that would be applicable (i.e., amounts the program would not pay) if the claim were paid in full. It does not matter whether the beneficiary is held liable for payment for the amounts. If the system does not retain actual coinsurance amounts, compute the 20% by subtracting the deductible amounts from net denied charges on line (E) and multiplying the remainder by 20%. Show coinsurance amounts that would have been applicable to SNF days and SNF demand bill days. If the actual coinsurance amount for each SNF bill cannot be determined, estimate it by applying the current year coinsurance rate to half of the SNF days reported. Enter this amount in category H. Coinsurance should be zero if there is a negative amount in column E.

EXAMPLE: The denied days reported in column A = 100. The coinsurance rate is $97.00 per day. Multiply 50 (1/2 of denied days) by $97.00 = $4850 estimated coinsurance.

I	Total Saved	This represents the total benefit savings after all computations. Computations are performed by the system.
J	Total Saved Including Waver Denials	This represents the total benefit savings including waiver. Computations are performed by the system.

For MR cost and number of bills reviewed, intermediaries enter data in the two items provided for each category as follows.

A	Number of Bills Reviewed	Enter the total number of bills reviewed by bill type.
B	MR Cost	Enter the MR cost by review type. The total MR cost should approximate Interim Expenditure Report (IER) costs for the quarter. However, there may be special implementation or other costs that can be excluded. The RO will advise

		you of costs to exclude. Do not enter cumulative costs.
C	Totals	Enter total number of bills reviewed and costs in the space provided.

For the number of bills reviewed, audits, and MR cost, intermediaries enter data in the following 4 items provided for each category.

A	Number of Bills Reviewed	Enter the number of bills reviewed.
B	Number of Providers Audited	Enter the number of providers audited on-site and in-house.
C	MR Cost	Enter cost of on-site and in-house audits.
D	Totals	Enter total number of bills reviewed, providers audits, and costs in the space provided.

9 - Retain Data to Support Savings Reported on the RBS - (Rev. 3, 11-22-00)

Intermediaries retain documentation to support the savings reported on the RBS for validation.

At a minimum, documentation must include:

- A record, by quarter reported, of each denied claim with the following data:
- Sufficient identification to retrieve the claim and medical documentation (if applicable);
- Amount of denied or deleted charges and/or number of denied days/visits;
- Deductible amount applicable to claim or which would have applied if claim was paid;
- Coinsurance amount applicable to denied days/charges or which would have applied if days/charges were paid (unnecessary if coinsurance is computed as in PIM Chapter 7 §8.2 subsection H above.);
- Charges/days paid under waiver; and
- Reviewer's ID or automatic denial indication.
- A record, by quarter, of reported days/visits and charges reversed on reconsideration/hearings and appeals.

An auditor or reviewer validating reported savings must be able to review contractor documentation and the claim to verify the entries on the report that the denial was made by the level of staff (or system) required for medical review, and that sufficient medical documentation (e.g., on the claim) was available to make the determination.

10 – List of MR Codes, Categories, and Conversion Factors for FY 2004 –

(Rev. 52, 10-10-03)

Report of Benefit Savings

Conversion Factors for FY 2004

Code	Category	Conversion Factor
1	Hospital PPS	100%
2	Hospital Non-PPS	78.63%
3	Hospital Outpatient	78.72%
4	Hospital Ancillary Charge	62.91%
5	SNF Days Non PPS	$266.39
6	SNF Outpatient Charges	72%
7	SNF Ancillary Charges	80%
8	ESRD	80%
9	Outpatient PT/Rehab	80%
10	CORF	80%
11	Rural Health Center	80%
12	Other Part B	80%
13	Program Integrity Savings	100%
14	Open Biopsy	$3,000 per review
15	All Audits	100%
16	SNF PPS & SNF PPS Demand Days	$266.39
17	SNF Non-PPS Demand Days	$266.39
18	HHA Skilled Nursing Visit	$ 97.38
19	HHA Speech Therapy Visit	$115.70
20	HHA Physical Therapy Visit	$106.47
21	HHA Aide Visit	$ 44.09
22	HHA Occupational Therapy	$107.19
23	HHA Medical Social Services Visit	$156.10
24	HHA DME/Supplies	80%
25	Outpatient HHA (Part B)	80%
26	Hospice	80%
27	CCR Skilled Nursing Visit	$ 97.38
28	CCR Speech Therapy Visit	$115.70
29	CCR Physical Therapy Visit	$106.47
30	CCR Aide Visit	$ 44.09
31	CCR Occupational Therapy Visit	$107.19
32	CCR Medical Social Services Visit	$156.10

Use conversion factors to convert charges to costs.

11 - Quality Improvement (QI) Program Reporting (Rev. 16, 11-28-01)

BI units shall assist in protecting the Medicare Trust Fund from those entities that would seek payment for items and services under false or fraudulent circumstances. This includes effectively developing potential fraud cases and referral of them to the Office of Inspector General (OIG) for determining if criminal and/or civil statutes have been violated.

In order to accomplish their responsibilities, CMS requires the Medicare contractors to develop BI QI programs. The purpose of the QI program is to systematically improve the quality of the

case referrals; enhance proactive approaches to identify potential fraud; and identify program vulnerabilities resulting from investigative activities. The QI plan shall be submitted each fiscal year to the RO 30 days before the beginning of the fiscal year. The content of the BI QI program shall:

1. *Ensure decisions made are effective in preventing, detecting, and deterring potential fraud in the Medicare program;*
2. *Ensure standard operational procedures are in place and are adhered to and monitored;*
3. *Improve the case development actions and documentation standards;*
4. *Ensure the proper handling of complaints;*
5. *Increase the potential acceptance of OIG case referrals by submitting quality referrals;*
6. *Improve the working relationship with law enforcement through enhanced networking and training;*
7. *Improve proactive use of data analysis;*
8. *Improve the quality of cases referred to law enforcement through partnering. Partnering is an informal meeting with law enforcement to discuss case details prior to referral;*
9. *Improve communication and coordination efforts with partners (OIG, FBI, other carriers, intermediaries, PSCs, etc.);*
10. *Implement and maintain a cross-functional data analysis team in each site. It will consist of representation from each functional unit and meet monthly to share data, observations of questionable billing practice patterns, voluntary refund information, and other concerns;*
11. *Improve and increase program safeguard actions including payment suspensions, prepayment review and referral to medical review, as appropriate;*
12. *Ensure proper maintenance and updating of the FID;*
13. *Ensure the accuracy of medical review decisions made in support of BI. The accuracy of these medical review determinations in support of BI whether made by BI or MR staff shall be a component of the BI QI program.*

(Utilizing this tool will increase the number of cases accepted by law enforcement and ensure the efficiency and effectiveness of the program.)

The contractor shall submit the results of the QI program to the RO on a quarterly basis. This report shall include the following information:

- *The date QI was performed and by whom;*
- *The program weakness or vulnerability;*
- *Source of the program weakness/vulnerability;*
- *How the program weakness/vulnerability was detected;*
- *The PIM chapter(s) and section(s) or Program Memorandum (PM) supporting the identification of the program weakness/vulnerability;*
- *Actions taken to correct the program weakness/vulnerability;*
- *Actions to avoid the same program weakness/vulnerability from recurring;*

- *How the weakness/vulnerability is being monitored for compliance;*
- *The results of individual and unit error rate percentages of quality reviews; and*
- *A synopsis of management practices within the context of the QI program.*

12 - Vulnerability Report--(Rev. 16, 11-28-01)

Program vulnerabilities can be identified through a variety of sources such as the Chief Financial Officer's (CFO) Audit, Fraud Alerts, the General Accounting Office (GAO), the Office of Inspector General (OIG), and contractor operations, as examples. Contractors shall submit any identified program vulnerabilities to CMS RO and CO on a quarterly basis. The identified vulnerabilities shall also include recommendations for resolving the vulnerability and describe the detection methodology.

The contractor shall send the CMS CO a copy of the identified vulnerabilities to the following address:

Centers for Medicare and Medicaid Services (CMS)
Division of Benefit Integrity and Law Enforcement Liaison (DBILEL)
Re: Program Vulnerabilities
Mail Stop C3-02-16
7500 Security Boulevard
Baltimore, Maryland 21244